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Information

Understanding Physicians' Rights and Liabilities Under the California Medical Practice Act

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THE RELATIVELY SECURE DOMAIN of the physician in California is being jeopardized by attacks upon his competence. An ever-increasing number of malpractice suits, many culminating in successful claims, as well as disciplinary actions by the state's Board of Medical Quality Assurance (BMQA) are challenging the physician's favored position in society.

In light of this growing problem, physicians no longer can practice medicine as they once did. It is essential that every California physician thoroughly examine all aspects of his practice and familiarize himself with his rights and liabilities under the state's Medical Practice Act and BMQA's enforcement procedures.

The Administrative Process

The purpose of disciplinary proceedings by BMQA is to protect the public from incompetent, dishonest or unprofessional licensees. BMQA, a division of the state's Department of Consumer Affairs, consists of three sections: Division of Medical Quality, Division of Licensing and Division of Allied Health Professions. The Division of Medical Quality utilizes approximately 45 investigators to review complaints against physicians. These complaints arise from anonymous sources, former employees, patients and other physicians. Complaints may also emanate from the division's own investigations, as in the case of any judgment or settlement in excess of $3,000 arising from a lawsuit involving negligence, error or omission in the practice of medicine.

Depending upon the results of the investigation, the matter might be referred by the investigator to the attorney general, a district attorney or a city attorney. A district or city attorney must limit his determination to whether there is any criminal violation. If he files charges against the physician, the penalty can be a fine and/or jail sentence.

The attorney general, on the other hand, determines whether there is cause for disciplinary action. A deputy attorney general analyzes the investigation report and accompanying material to determine whether there is sufficient evidence to warrant filing an "accusation." This is the initial pleading in licensing proceedings.

The accusation must set forth in ordinary, concise language the acts or omissions with which the physician is charged (thereby enabling him to prepare his defense) as well as the statutes and rules which the physician is alleged to have violated. After the accusation is prepared by the deputy, it is sent to BMQA for signature and filing. Usually BMQA's executive director signs the accusation; he is the complainant. After the accusation is returned to the deputy, it is served on the physician by certified mail.

There is no statute of limitations requiring that the accusation be filed within a prescribed period of time. Nevertheless, BMQA must prosecute promptly. If delay prejudices the physician's rights, a motion to dismiss the accusation might be entertained.

A physician receiving an accusation should immediately consult an attorney, preferably one with experience in disciplinary matters before the Division of Medical Quality. It is necessary to file, within 15 days, a "notice of defense" form, which sets forth the physician's request for an administrative hearing. If he fails to file the notice, the matter will proceed by default, and his license almost certainly will be suspended or revoked. On receipt of the physician's notice of defense, the Office of Administrative Hearings will assign an administrative law judge to hear and decide the case. Depending upon the anticipated duration of the hearing, it will begin three to six months after filing of the accusation.

The physician is entitled to know the names, addresses and statements of all witnesses against him. In addition, the physician has the right to

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obtain copies of all written and other documentation admissible into evidence, as well as investigative reports. This procedure, known as "discovery," must be initiated within 30 days after service of the accusation. If discovery is thwarted, the physician may compel it by filing a petition in superior court.

At the hearing, the deputy attorney general produces oral and documentary evidence to sustain the allegations in the accusation. The physician has the right to cross-examine the witnesses who testify against him. After the complainant rests his case, the physician presents evidence in his favor by testifying himself and by calling witnesses in his behalf. Any relevant evidence is admissible, including hearsay evidence (an out-of-court statement made by someone other than the witness). Although hearsay evidence alone is not sufficient to support a finding by the administrative law judge, it is admissible to supplement or explain other evidence.

After presentation of evidence is completed, the administrative law judge receives oral or written argument from the parties. The administrative law judge then prepares a written "proposed decision." This document, usually several pages long, contains findings of fact, determination of issues and a recommended penalty or disposition of the case.

Even if there are grounds for disciplinary action, there could be circumstances where it would not be in the public interest to impose a penalty (for example, the physician technically violated the law, but there are mitigating or extenuating circumstances). Although it is possible the proceedings could be terminated without a penalty, as by dismissal of the accusation, this type of disposition is disfavored. Penalties can range from a stayed suspension with a minimal conditions of probation to an actual suspension or revocation of medical license.

The Division of Medical Quality may adopt the proposed decision in its entirety or may reduce the penalty without examining the transcript of the hearing. On the other hand, if the division decides to increase the penalty, it must order the hearing transcript from the Office of Administrative Hearings. After the transcript is prepared but before the division issues its decision, each party is afforded another opportunity to present oral or written argument.

In the event the decision is unfavorable, the physician may petition for reconsideration. In this regard, a stay of the decision may be desired to afford the physician sufficient time to prepare his petition or to "put his affairs in order" in the event a suspension or revocation is imposed.

If the petition is denied, the matter can be appealed to superior court. *Judicial* review may be sought by filing a "petition for writ of mandate." It is crucial that this be filed within 30 days after the last day on which reconsideration superior court, the physician must establish that can be ordered. If a stay is sought from the there is no harm to the health and safety of the public and that it is not likely the division will prevail on appeal. This is an onerous burden, which can be lightened considerably with the help of an attorney experienced in these matters.

Grounds for Revocation or Suspension

The various grounds for disciplinary action are set forth in the Medical Practice Act (Business and Professions Code, commencing at Section 2000). The provisions most frequently utilized by the division as the basis for disciplining physicians are aiding or abetting any unlicensed person to practice medicine; the commission of any act involving moral turpitude or dishonesty; conviction of a felony or any offense involving moral turpitude; prescribing without a good-faith prior examination; intoxication-related offenses; gross negligence; and incompetence.

The list of grounds for disciplining is extensive, and each such ground may include a variety of circumstances. However, a physician has a number of potential defenses available to him. He may assert that the patient did not elect to undergo the treatment plan or procedure he recommended; that the unlicensed activity or misconduct which allegedly was performed on his premises was not at his direction, nor did he have knowledge of it; that all alleged deficiencies were corrected prior to the filing of the accusations; or that the patient deliberately fabricated the allegations.

These potential defenses are in addition to any claims of unconstitutionality of the statutes or rules or of violation of due process or other rights guaranteed to the physician by the Constitution. Evidence in mitigation or evidence tending to show rehabilitation are crucial in disciplinary matters.

When a physician's competence is at issue, he is

1. *History*—Is a complete history taken of each new patient? Is it frequently updated?
2. *Treatment*—Has a straightforward and honest appraisal of the patient's condition been presented to him? What treatment is indicated? What tests are or may be required? Should the patient be referred to a specialist? Are all alternatives carefully explained? Are all of the uncertainties and potential complications fully described? Is an experimental procedure being utilized? Are sufficient records maintained?
3. *Drugs*—Is the prescription clear? Is the patient advised of possible undesirable effects? Is a duplicate copy stapled to the patient's chart or is a separate one-page medication record maintained as in the case of hospital charts? Are his allergies and other past reactions to treatments or drugs carefully noted?
4. *Informed consent*—The treatment plan or medical procedure should be set forth and documented. If practical, it should be signed by the patient several days before treatment is started. A physician should inform his patient of what he is going to do and of possible complications that might result from his treatment or procedure. This is known as informed consent. It is important that a physician *document* that he has provided the following information to the patient: (1) a statement of what kind of operation or treatment is to be carried out; (2) what kind of anesthesia will be used, if any; (3) what side effects and minor discomforts are associated with such operation or treatment; (4) what are some of the serious health problems or complications; (5) whether the procedure is irreversible: (6) what are the alternatives, if any. There must be some *documentation* of the factual statements of the discussion between physician and patient. A mere statement that the "risks, complications and alternatives were explained" is insufficient because these are conclusions; the underlying facts must be recorded.
5. *Personnel*—Are the duties and responsibilities of each employee clearly identified and, if possible, written down in an employee "handbook"? Is there an employment contract that embodies these duties? Does each employee know the limits of his responsibility? If an employee is licensed, a copy of his certificate should be placed in the personnel file.
6. *Medi-Cal (Medicaid)*—Who prepares and completes Medi-Cal program claims forms? What checks and balances have been established? Who signs these forms? Are the responsible employees familiar with current regulations?
7. *Laws*—Every California physician should have a current copy of the state's Medical Practice Act (issued by BMQA), and it should be reviewed from time to time. Medi-Cal laws and regulations should be examined and understood; these can be obtained from the California Department of Health Services.

Figure 1.—Checklist for Medical Practices

well advised to establish an abundance of expert evidence supporting his treatment plan or procedures. A physician is not expected to be a guarantor of successful results, nor is he required to possess a perfect knowledge of medical principles. A physician will not be held responsible for following courses of action that subsequently prove erroneous, provided he has not deviated from commonly accepted procedures. However, to be right is not enough; the physician must present a vigorous defense, if he is to protect his license.

While there is no substitute for individual legal counseling, a checklist (Figure 1) is offered as an aid in evaluating the legal implications of various elements of medical practice. These areas and many others should be the subject of continued scrutiny.